BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **SUSAN B. FLEMING, M.D.** Holder of License No. 14840 For the Practice of Medicine In the State of Arizona.	Case No. MD-13-0480A Case No. MD-13-0883A Case No. MD-14-0266A **ORDER FOR SURRENDER OF LICENSE AND CONSENT TO THE SAME**

Susan B. Fleming, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Order for Surrender of License; admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order by the Board.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 14840 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated the above referenced cases after receiving complaints as follows:

   a. MD-13-0480A after receiving a complaint from a pharmacist regarding the care and treatment of 51 year-old female patient ("GM"), alleging inappropriate/excessive prescribing, and inadequate medication management.

   b. MD-13-0883A after receiving a complaint regarding the care and treatment of 54 year-old male patient ("ML"), alleging inappropriate/excessive prescribing of narcotics.

c. MD-14-0266A after receiving a complaint regarding the care and treatment of 54 year-old male patient ("DM") alleging inappropriate prescribing.

MD-13-0480A- Patient GM

4. GM's initial appointment with Respondent occurred on August 10, 2012 and she was described by Respondent as exhibiting signs of withdrawal with agitation and nausea. Respondent documented a physical exam, but did not document vital signs, or auscultation of the heart or lungs. Respondent's treatment plan included having GM sign a pain management agreement, sending urine for confirmatory testing, and continuing prescriptions for Oxycodone, lorazepam, and Zoloft, with a two week follow up.

5. On August 28, 2012, Respondent increased GM's Methadone, while continuing GM's Oxycodone on its regular schedule. On September 26, 2012, Respondent noted that GM continued to experience joint swelling and pain was as well as facial pain from scleritis. Respondent ordered GM to continue Methadone and Oxycodone as needed.

6. On November 20, 2012, Respondent noted that GM was in considerable pain, and described impairment of physical activity. Respondent started GM on Oxycontin, and told her to continue her Methadone and Oxycodone.

7. On December 6, 2012, GM reported to Respondent that she was able to discontinue her Methadone use with the addition of Oxycontin. Respondent instructed GM to increase her Oxycodone to address GM's complaint of dizziness.

8. On January 4, 2013, GM reported continued pain, but stated that it was better with Oxycontin and Oxycodone. Respondent instructed her to continue these medications.

9. In March, 2013, GM reported to Respondent that the medication combination helped, but that she continued to have pain. Respondent instructed her to continue her medications and added oxymorphone.

10. On April 24, 2013, GM was seen with an acute flare of arthritis, multiple joint swelling and tenderness, and GM received an intramuscular Kenalog injection. She was instructed to continue Oxycontin with Oxycodone as needed. Respondent made an addendum to her chart note for this date stating that she received a call from a pharmacist concerned that less than thirty days elapsed between prescription refills. There were no clinical notes for review subsequent to the note of April 24, 2013. Two letters included in the records for review were noted to be from prescription review services in December of 2012 and April of 2013 addressed to Respondent. The letters stated that their reviews had identified GM as having unusual medication utilization patterns with possible indication of drug over utilization. Respondent's response indicated that GM's current therapy was appropriate and medically necessary for GM to continue.

11. The standard of care requires a physician to evaluate the chronic pain patient, including review of diagnostic studies and prior interventions as well as drug history. Respondent deviated from the standard of care by failing to obtain medical records from GM's prior pain management provider.

12. The standard of care requires a physician to obtain complete vital signs of the patient, including checking the patient's' blood pressure, heart rate or oxygen saturation in addition to recording height and weight. Respondent deviated from the standard of care by failing to check GM's blood pressure, heart rate or oxygen saturation.

13. The standard of care requires a physician to monitor (and address as indicated) the frequency of the patient's opioid prescription fills. Respondent deviated

from the standard of care by failing to monitor the frequency of opioid prescription fills by patient GM.

14. The standard of care requires a physician to consider treatment modalities other than opioids and steroid injections. Respondent deviated from the standard of care by failing to consider treatment modalities other than opioids and sterold injections for GM.

15. The standard of care requires a physician to adequately work up or consider factors contributing to the patient's reported lack of pain control, and to avoid providing significant opioid dose escalation. Respondent deviated from the standard of care by providing significant opioid dose escalation for patient GM without adequate workup or consideration of factors contributing to GM's reported lack of pain control.

16. The standard of care requires a physician to monitor, recognize, and evaluate problems associated with opioid-related disorders. Respondent deviated from the standard of care by failing to monitor, recognize, and evaluate problems associated with opioid-related disorders for patient GM.

17. As a result of Respondent's actions, GM was placed at increased risk of harm from drug toxicity, drug overdose, respiratory depression, aspiration, sleep apnea, endocrine dysfunction, neurologic impairment, and death from the levels of prescribed opioids. GM did not receive any other forms of treatment to help with pain management such as pool therapy, other forms of physical therapy or occupational therapy to assist with adaptive equipment, edema management and body mechanics training, or psychological pain management training to help with quality of life issues and self-care techniques.

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MD-13-0883A- Patient ML

18. In 2002, patient ML sustained a 30-40 foot fall at work and subsequently developed chronic pain symptoms in his lower back radiating to his left thigh. He failed a series of steroid injections for his symptoms and over several years, had built up a tolerance to a fairly high-dose narcotic regimen from his pain doctor. During ML's five years with his pain doctor, he was able to work full-time without any deleterious side effects. In 2007, ML transferred his care to Respondent's clinic. Prior to that transfer, ML's pain doctor noted that the narcotic dosage had reached a very high level and he wished to titrate ML off the high prescription.

19. Respondent assumed care of ML and continued his high-dose treatment regimen of the long acting narcotic Oxycontin and a breakthrough prescription for Oxycodone. Per Respondent's notes, it appeared to be working satisfactorily, and ML continued to hold a full-time job. Over the next six years, Respondent continued to treat ML with a relatively similar dose of Oxycontin while significantly increasing his use of the breakthrough medications Oxycodone and oral morphine ("MSIR"). ML's doses under Respondent's care reached the levels of 1,440mg of Oxycontin per day, 660mg of Oxycodone per day, and 360mg of MSIR per day.

20. The standard of care when the dose of a drug becomes uncommonly high requires a physician to begin a taper where the patient is slowly weaned off the drug in order to attenuate the built-up tolerance, or to switch to other narcotic formulations to minimize a growing dependency on one substance. Respondent deviated from the standard of care by failing to suggest a narcotic taper and by failing to document an opioid rotation.

21. As a result of Respondent's actions, ML was at risk for opioid hyperalgesia and low testosterone levels, which could lead to osteoporosis and muscle pain. ML was treated with hormone replacement to minimize this effect.

MD14-0266A- Patient DM

22. Patient DM established care with Respondent on February 14, 2003 with a subjective complaint of chronic neck and right upper extremity pain. Treatment up to March 2007, included continuous prescriptions of Oxycodone and Methadone in increasing amounts. Respondent also treated DM with Valium.

23. In May 2007, Respondent's records show that DM was taking Oxycodone at 30mg up to six times a day and Methadone at 120mg per day (60mg twice daily). During DM's visits in May, July and November 2007, Respondent observed that DM had normal posture and gait, otherwise, there was no physical examination relevant to DM's chronic neck pain. In September 2007, DM complained of constipation and Respondent provided him with samples of Miralax.

24. In January 2008, DM complained of acute strain of the left mid back region that was almost completely resolved with use of Valium and heat. Respondent's records show a physical examination revealing minimal tenderness and no spasm in the thoracolumbar junction. In November 2008, Respondent introduced a new patient questionnaire for DM to complete at each visit. At that time, DM stated that he was being treated for pain conditions of the low back, occasional sciatica, nerve damage and trapezius. At no time in 2008 did Respondent's records show a physical examination that supported ongoing opioid management of subjective discomforts related to the neck. None of the previous records for DM demonstrate a history, physical examination, or diagnostic work obtained by Respondent for chronic lumbar pain. Respondent's records

for DM in 2008 reference continued prescriptions for Methadone at 120mg per day and unspecified continued doses of Oxycodone.

25. In 2009, Respondent's records reflect treatment of DM for lower back pain; however, Respondent failed to document a pain history, physical examination or diagnostic work-up regarding DM's complaint. Respondent's records reference continued Methadone treatment at 120mg per day and Oxycodone at unspecified amounts. Pharmacy records show that DM was taking an average of six 30mg Oxycodone daily as prescribed by Respondent. Also, while Respondent's records do not reflect any prescriptions for Diazepam, pharmacy records show that DM received seven prescriptions for #100 Diazepam 5mg tablets in 2009.

26. Respondent continued to prescribe DM Methadone 120mg per day, Oxycodone at unspecified doses, and Vallum as needed for muscle spasms throughout 2010. DM reported occasional sleepiness and constipation. Respondent's records show repeated normal physical examinations, but no objective findings to support ongoing opioid management of subjective neck and low back pain.

27. On November 10, 2010, Respondent provided DM with an "extra prescription for Oxycodone to cover the expected pain from the planned dental work," but did not indicate what dental work was planned, or why it would require an additional prescription. Pharmacy records show that Respondent provided DM with two prescriptions for 30mg Oxycodone at #240 each on November 3 and 10, 2010, both of which were dispensed.

28. In 2011, Respondent's documentation shows consistent physical examinations with normal gait and posture, and no abnormal findings providing an objective basis for ongoing opioid management of DM's subjective complaints of neck and low back pain. DM continued to report occasional constipation that was controlled

with diet and Miralax. Respondent continued to prescribe Methadone at 120mg per day and Oxycodone at unspecified doses. Pharmacy records show that DM obtained monthly prescriptions of #260 Oxycodone 30mg. In 2011, Respondent's records do not show prescriptions for Diazepam; however, pharmacy records show that DM obtained ten prescriptions for 100 pills of 10mg Diazepam.

29. On DM's March 1, 2011 visit, DM disclosed to Respondent that he had obtained Percocet from an oral surgeon for an urgent dental procedure. At that same visit, Respondent prescribed an "extra" Oxycodone prescription "to cover future dental work." There is no reference in Respondent's records regarding contact with the dentist to coordinate care regarding the dental work and additional prescription. Pharmacy records show that DM filled an additional 360 pill prescription for Oxycodone 15mg and a 360 pill prescription for Oxycodone 30mg in March. In April 2011, Respondent provided DM with samples of Testim followed by a monthly prescription for compound testosterone cream for hypogonadism for a subjective complaint of daytime drowsiness. Respondent did not obtain initial laboratory values for DM's testosterone.

30. Pharmacy records for DM in 2012 show that he continued to receive monthly prescriptions for #360 Oxycodone 30mg, #360 Methadone 10mg, and #100 Diazepam 5mg. Respondent's records consistently reflected limited physical assessments with normal posture and gate noted. Respondent's records do not reference the prescriptions for Diazepam that were being filled by DM. At DM's May 9, 2012 visit, Respondent prescribed DM an "extra" #360 Oxycodone 30mg prescription for unspecified anticipated dental surgery and a subjective complaint of exacerbation of lower back pain. In October 2012, Respondent prescribed DM Adderall 5 to 10mg per day for excessive daytime sleepiness attributed to pain medication based on DM's self-report that he had used it in the past with good results. Respondent's records do not show that

baseline blood pressure and heart rate were obtained at the time Adderall treatment was initiated by Respondent.

31. Pharmacy records show that DM obtained prescriptions from Respondent for Adderall 10mg daily on November 14, 2012 and January 31, 2013. At DM's April 2013 visit, Respondent noted that DM "uses Adderall for ADHD symptoms. He uses this intermittently due to cost issues." Respondent increased DM's Adderall prescription that same month to 30mg daily and pharmacy records show that the prescription was provided on a monthly basis thereafter. Respondent did not obtain relevant vital signs for blood pressure or pulse from the date Adderall treatment was initiated through February 2014.

32. In 2013, Respondent's limited physical examination reflected normal gait and posture and no abnormal findings to support DM's ongoing opioid medication prescriptions for subjective complaints of neck and low back pain. Respondent's records show that DM continued to utilize Miralax for constipation. In 2013, Respondent's records do not reference any Diazepam prescriptions; however, pharmacy records show that DM filled prescriptions on six occasions for #100 Diazepam 5mg from Respondent.

33. At DM's July 2013 visit with Respondent, she prescribed DM Dilaudid 4mg 12 tablets daily, apparently related to DM's difficulty in obtaining an adequate supply of Oxycodone from pharmacies. Respondent ultimately transitioned DM to a combination of Methadone 120mg per day, Oxycodone 30mg six times a day and Dilaudid 4mg, 12 tablets daily. At DM's December 2013 visit, Respondent provided DM with an extra prescription for #180 Oxycodone 15mg tablets for a recent wrist fracture that DM had already received treatment and a prescription for Ibuprofen from the VA. There is no reference in Respondent's records regarding whether she attempted to coordinate care with the VA provider.

34. At DM's February 2014 visit with Respondent, records show DM continued to use the extra Oxycodone 15 mg, six times daily prescription for pain from his healed wrist fracture. Pharmacy records show that DM also continued to fill prescriptions for #360 Methadone 10 mg, #180 Oxycodone 30 mg and #360 Dilaudid 4 mg.

35. Respondent's records contain results of urine drug screening performed on April 27, 2007, May 15, 2008, February 24, 2009, April 8, 2010 and June 16, 2011. A handwritten notation in the record references urine drug screens performed on October 23, 2012 and May 31, 2013 but the results are not contained in the record.

36. The standard of care requires that in addition to initial assessment, ongoing opioid prescribing should be accompanied by intermittent reassessment of the underlying pain problem to determine if ongoing opioid prescribing is warranted, and/or if there has been interval development of new or progressive pathology. This includes targeted physical re-examination, updated diagnostic testing and specialist consultation as indicated. Given the strong evidence for serious risks of long term opioids – many of which significantly increase with long term use, the standard of care requires a physician to periodically reassess and determine if there continues to be clinical evidence of an objective pain generator which warrants continued opioid prescribing. Respondent deviated from the standard of care by failing to perform a reassessment at any time to identify objective clinical evidence of a pain generator warranting continued high dose opioid management of DM's subjective complaints.

37. The standard of care requires a physician to have an individualized chronic pain management treatment plan and include consideration not only of opioid medication, but also noninvasive techniques, behavioral strategies, physical therapy, non-opioid medications, and specialist consultations as indicated. Respondent deviated from the standard of care for patient DM by relying heavily on high dose opioids and unjustified

dose escalations for subjective discomforts in the absence of a coordinated multidisciplinary treatment plan, and without adequate attention to alternative treatments.

38. The standard of care requires a physician to investigate increasing or new pain complaints for potentially treatable disease progression or new pathology prior to significant dose escalations in excess of expected development of physiologic tolerance. Respondent deviated from the standard of care for patient DM by providing significant dose escalations in excess of that expected for physiologic tolerance, in the absence of investigation or identification of any pathology to warrant such increases, and by providing unjustified dose escalations in the absence of any diagnostic work up or specialty consultation to determine if there is treatable or objective pathology associated with DM's escalating subjective complaints.

39. The standard of care requires a physician to properly inform the patient of the cardiac risk associated with Methadone prescribing, obtain a detailed personal and family history related to cardiac risk factors, and to perform ECG screening. Respondent deviated from the standard of care for patient DM by prescribing significant doses of Methadone for eleven years, the past seven of which were after an FDA safety alert, and the past five years were after wide dissemination of Methadone prescribing guidelines related to the cardiac risks associated with such treatment. Despite this, at no time is there documentation that Respondent informed DM of the cardiac risk, obtained a detailed personal and family history related to cardiac risk factors, or performed ECG screening.

40. The standard of care requires a physician to base the decision to concurrently prescribe opioid and benzodiazepine on well documented and reasonable medical rationale, as this combination is well known to significantly increase the risk of respiratory depression, accidental overdose and death. Respondent deviated from the

standard of care for patient DM by failing to document a rationale to warrant the risks of long term prescribing of Diazepam in combination with high dose Methadone and Oxycodone.

41. The standard of care requires a physician to coordinate care with the patient's other treating physicians. Respondent deviated from the standard of care by providing large quantity Oxycodone prescriptions for patient DM's anticipated post-dental procedure pain on three separate occasions; and for DM's complaint of persistent wrist pain without contacting the dentist or the patient's treating physician.

42. The standard of care requires a physician to establish the criteria for diagnosing adult ADHD and/or determining appropriateness of a stimulant prior to prescribing the medication. Respondent deviated from the standard of care for patient DM by prescribing monthly stimulant medication for one year, having failed to establish even the absolute minimum criteria for diagnosing adult ADHD and/or determining the appropriateness of stimulant medication.

43. The standard of care prior to prescribing testosterone requires a physician to obtain lab verification that the condition exists, and when prescribing long term, the standard requires a physician to monitor the patient with lab testing every six months. Respondent deviated from the standard of care for patient DM by prescribing testosterone replacement for one year, in the absence of initial documentation of low testosterone levels on laboratory testing and without monitoring testosterone levels during treatment.

44. The standard of care prior to introduction, continuation and/or escalation of long term opioids for chronic pain requires a physician to closely monitor the patient for non-compliance and/or aberrant drug seeking behavior. Respondent deviated from the standard of care by failing to closely monitor patient DM for non-compliance and/or aberrant drug seeking behavior.

45. Respondent's actions perpetuated an iatrogenic physical and emotional dependence on ultra-high doses of narcotics for patient DM, in the absence of any objective evidence to support the treatment. As a result, DM was unnecessarily exposed to risk of long term harms of these medications and by failing to periodically assess DM's underlying condition for associated new or progressive pathology, a potentially treatable new or progressive cause for his subjective symptoms may have been overlooked. Additionally, DM developed a motor and sensory ulnar neuropathy that took months to resolve, after falling asleep in a sitting position, leaning on his elbows. This is an unusual development in an individual who is not cognitively impaired, as the ulnar pain from this sleeping position would awaken most cognitively intact patients prior to development of prolonged motor dysfunction.

46. Additional potential harms of Respondent's chronic high dose opioid treatment for patient DM include hypogonadism, narcotic bowel syndrome (up to and including small bowel obstruction), osteoporosis, sleep apnea, opioid induced hyperalgesia (increased sensitivity to pain) and opioid induced mood disorder (anxiety, depression and/or apathy).

47. Methadone related potential harm for patient DM includes a potentially fatal cardiac event due to abnormal heart rhythms associated with high dose Methadone that can occur in the absence of any ECG monitoring. Adderall related potential harm for patient DM includes stimulant abuse, addiction, and diversion, as well as insomnia, anorexia, headaches and social withdrawal. Testosterone related potential harm for patient DM in the absence of documented hypogonadism or monitoring of serum testosterone during treatment, includes unnecessary exposure to exogenous testosterone which has been implicated in increased risk of prostate disease including prostate cancer, as well as increased cardiovascular risk.

48. Respondent admits to the acts described above and that they constitute unprofessional conduct pursuant to A.R.S. §32-1401(27)(q) ("[a]ny conduct that is or might be harmful or dangerous to the health of the patient or the public.")

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board possesses statutory authority to enter into a consent agreement with a physician and accept the surrender of an active license from a physician who admits to having committed an act of unprofessional conduct. A.R.S. § 32-1451(T)(2).

ORDER

IT IS HEREBY ORDERED THAT Respondent immediately surrender License Number 14840, issued to Susan B. Fleming, M.D., for the practice of allopathic medicine in the State of Arizona, and return her certificate of licensure to the Board.

DATED and effective this 11th day of March, 2016.

ARIZONA MEDICAL BOARD

By: Patricia E. McSorley
Patricia E. McSorley
Executive Director

CONSENT TO ENTRY OF ORDER

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent acknowledges she has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

3. By consenting to this Order, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Order in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Order.

4. The Order is not effective until approved by the Board and signed by its Executive Director.

5. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Although Respondent does not agree that all the Findings of Fact are set forth in this Consent Agreement are supported by the evidence, and although Respondent does not agree that certain of the Findings of Fact have any relevance to the Conclusions of Law, Respondent acknowledges that it is the Board's position that, if this matter proceeded to formal hearing, the Board could establish sufficient evidence to support a conclusion that certain of Respondent's conduct constituted unprofessional conduct. Therefore, Respondent has agreed to enter into this consent agreement as an economical and practical means of resolving the disputed issues associated with the complaint filed again her. Further, Respondent acknowledges that the Board may use the evidence in its possession relating to this Consent Agreement for purposes of determining sanctions in any further disciplinary matter.

7. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

8. The Order is a public record that will be publicly disseminated as a formal disciplinary action of the Board and will be reported to the National Practitioner's Data Bank and on the Board's web site as a disciplinary action.

9. If any part of the Order is later declared void or otherwise unenforceable, the remainder of the Order in its entirety shall remain in force and effect.

10. If the Board does not adopt this Order, Respondent will not assert as a defense that the Board's consideration of the Order constitutes bias, prejudice, prejudgment or other similar defense.

Susan B. Fleming, M.D.

Dated: 2/29/2016

EXECUTED COPY of the foregoing mailed by US Mail this 11th day of March, 2016 to:

Susan B. Fleming, M.D.
Address of Record

Stephen Myers
Myers & Jenkins
714 E. Rose Lane, Suite 100
Phoenix, AZ 85012
Attorney for Respondent

ORIGINAL of the foregoing filed this this 11th day of March 2016 with:

The Arizona Medical Board
Board Coordinator
Arizona Medical Board
9535 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Mary Bibey
Board Staff